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THE EFFECTIVENESS OF FEDERAL CHILD AND MATERNAL HEALTH PROGRAMS

HEARING

BEFORE THE

SUBCOMMITTEE ON ECONOMIC GOALS AND INTERGOVERNMENTAL POLICY

OF THE

JOINT ECONOMIC COMMITTEE

CONGRESS OF THE UNITED STATES

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THE EFFECTIVENESS OF FEDERAL CHILD AND MATERNAL HEALTH PROGRAMS

WEDNESDAY, NOVEMBER 2, 1983

CONGRESS OF THE UNITED STATES,
SUBCOMMITTEE ON ECONOMIC GOALS AND
INTERGOVERNMENTAL POLICY
OF THE JOINT ECONOMIC COMMITTEE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room SD-628, Dirksen Senate Office Building, Hon. Lloyd Bentsen (vice chairman of the subcommittee) presiding.

Present: Senator Bentsen.

Also present: George R. Tyler, professional staff member.

OPENING STATEMENT OF SENATOR BENTSEN, VICE CHAIRMAN

Senator BENTSEN. The hearing will come to order. Ladies and gentlemen, welcome to this hearing. It is designed to examine the effectiveness of Federal programs to promote maternal and child health care.

One of the problems we have run into in the Congress when it comes to maternal and child health care is that you do not have a vocal constituency. You do not have political pressure groups that focus extensively on this area, as you do when you get into programs for the elderly, for example. Those programs have a high profile. Political force is involved. Those are people who vote. They go to the polls and you see a correlation in their political effectiveness and results here in the treatment of their programs.

But that is just not the case when it comes to children. And it is of major concern to me that we are seeing a situation where we have not had the continuing attention recently to the extent that I think we have had it in the past to their health problems.

We are conducting these hearings to try to gain a better understanding of what is the actual impact on maternal health care and child health care, of the specific spending cuts that have taken place under the current administration.

Since the 1960's, this Nation has made a concerted effort to improve the health of children and infants, including prenatal care. This effort was initiated in recognition that these groups are among the most vulnerable segments of our society. Particularly when in lower income or inaccessible households, pregnant women and infants faced substantial economic barriers that deprived many of the fundamental opportunity for good health from birth. The restricted access, particularly to prenatal care, of some expectant mothers was a major cause of un-

derweight births and associated needless handicapping conditions—conditions which carried heavy lifetime emotional costs to families and economic costs to both families and taxpayers. Our Nation was simply not dealing in either a cost-effective or a humanitarian fashion with infant health care issues. Far too many Americans were being born with avoidable handicaps or with poor odds of survival.

The response was the establishment of a handfull of programs which were partially or solely targeted at improving maternal and child health care. These include a portion of medicaid expenditures for infants and youths; the national childhood immunization program; the WIC and community health center programs; and the MCH block grants.

Those programs have been successful. The most sensitive indicator of a nation's infant health is the infant mortality rate. As we see in the first table, growth in our Federal child health programs has paralleled a substantial decline in the U.S. infant mortality rate since the 1960's. In fact, our infant mortality rate fell 40 percent during the last decade alone; 40 percent. It took 25 years, well over twice as long, to achieve a comparable reduction in that rate in the absence of these targeted programs during the 1950's and 1960's.

The programs have more than doubled the pace of our progress in combating infant deaths and avoidable handicaps. That progress has been hard won and it has been expensive. Yet the quality of our maternal and child health still does not match that abroad.

The second table contains current infant mortality data for a number of industrialized nations. It shows that we still have a mediocre or worse record in child and maternal health care. Internationally, we only run in the middle of the pack; 17 nations had lower infant mortality rates than we did in 1980, for example, including Hong Kong, Ireland, and Spain.

Sweden and Japan enjoyed infant mortality rates a large 40 percent better than our own. Had the United States simply matched Japan, over 17,000 fewer babies would have died here in 1980, and many thousands of others would be free of handicaps today.

It is not just the ones which die that concern us; it is the ones who survive, but with severe handicaps and emotional burdens for the rest of their lives that concerns us as well.

Last month the Finance Committee passed my amendment providing prenatal health coverage for first-time pregnancies. And 2 years ago I fought the administration and was successful in establishing the MCH program as a separate and distinct block grant program.

These and other efforts in Congress were designed to insure that our progress in infant and prenatal health care would continue. A key factor determining whether that progress continues is the availability of funds. Our Nation faces enormous $200 billion deficits well into the future. And Congress faces difficult choices in determining how best to balance spending priorities while trying to shrink the deficit. The series of hearings I am kicking off today are designed to provide Congress with information needed to better make those choices.

[The tables referred to follow:]

U.S. CHILD AND MATERNAL HEALTH

FISCAL YEAR	CHILD HEALTH EXPENDITURES 1/	U.S. INFANT MORTALITY RATE 2/
1968	$ 831.5	21.8
1969	1,017.2	20.9
1970	1,239.0	20.0
1971	1,449.2	19.1
1972	1,574.2	18.5
1973	2,093.4	17.7
1974	2,326.3	16.7
1975	2,806.6	16.1
1976	3,211.4	15.2
1977	3,406.5	14.1
1978	3,735.6	13.8
1979	4,057.3	13.1
1980	4,622.6	12.5
1981	5,209.2	11.7
1982	5,168.2	11.2

1/ MCH, WIC, Medicaid (under 21 years), Community Health Centers, Childhood Immunization and CSFP. Millions of Dollars.

2/ Deaths per 1,000 live births, Calendar Year.

Infant Mortality Rates

1980

Country	Deaths per 1,000 Births
Sweden	6.7
Japan	7.4
Finland	7.6
Denmark	8.5
Norway	8.8
France	10.0
Canada	10.9
Spain	11.1
Ireland	11.2
Hong Kong	11.2
Australia	11.4
U.S.	12.5

Senator BENTSEN. Today, we will be hearing from two distinguished experts in the maternal and child health care field. Dr. Peter Budetti of the University of California will discuss the effectiveness of the medicaid program and Dr. Antoinette Eaton of Ohio State University and the Columbus Children's Hospital will discuss the effectiveness of the MCH block grant program. Our third scheduled witness, Dr. Arden Miller, I understand, is in bed with the flu at home in North Carolina. We wish him a speedy recovery. Which reminds me, I better get my flu shot.

Dr. Miller had consented for us to release a summary of the study he was to discuss this morning, which he prepared under the auspices of the United Nations. His study examined the impact of the two most recent recessions on child health in the United States and found that the mix of Federal programs for children—including MCH, WIC, medicaid, childhood immunization, and the CHH program—had a direct and significant impact on the availability and quality of health care for this Nation's children. His study is an important one and I encourage you to review the summary we have here today.

[The summary statement of Dr. Miller follows:]

Summary Statement of C. Arden Miller, M.D., Professor and Chairman, Department of Maternal and Child Health, School of Public Health, University of North Carolina at Chapel Hill

The Recent Economic Crisis and the Health of Children

Summary of Funding of a Forthcoming Report Prepared by the Author and Colleagues for the United Nations Children Fund on The World Economic Crisis and the Children, United States Case Study.

- No existing data systems are entirely adequate for reporting on the health status of children in a timely fashion. Long delays in the availability and analysis of data diminish the value of many national surveys. The development of public policy needs to be informed, not only by periodic surveys, but by a continuous national monitoring process that reports promptly on fluctuations in health status and on risks affecting children. This kind of careful and continuous monitoring should rely increasingly on health outcome measures and on sentinal indicators.

- In the United States the monitoring of children's health must focus on sub-groups such as those who are disadvantaged for reasons of poverty, discrimination, or geographic isolation. The majority of the population in the United States can command sufficient resources to cushion itself against all but the most drastic changes in the Nation's economy. Serious neglects and hardships for population sub-groups are concealed by dealing only with aggregate data. The measures for children's health need to include some that will have meaning to relatively small groups of children over short time spans. Recommendations have been made for such measures in other publications.

- Ample evidence exists that children living in poverty suffer adverse health consequences and that the proportion of children living in poverty in the United States has increased steadily since 1975 and dramatically since 1981. Every fifth child in the United States lives in a poverty level household. Two trends account for the large and growing number of children in poverty. The first is the high unemployment rate and the second is the great increase in the proportion of households that are headed by women. This circumstance has been called the "feminization" of poverty; it dramatically affects the well-being of dependent children.

- Most measures of health status and health risks for children show steady improvements throughout the 1970s. This improvement is remarkable in view of the serious recession of 1974-75 with unemployment rates that rivaled those of 1981-82, and all the more remarkable because of the increasing proportion of children living in poverty after 1975. The available measures of health status and risks to children appeared to improve in spite of these adverse economic trends.

- Throughout the 1970s the exercise of public responsibility for financing and providing essential services and supports held constant or improved. Many kinds of health benefits were especially striking during the 1974-75 recession. These circumstances suggest that the public supports and services had a

cushioning effect that mitigated against the adversities of unemployment and impoverishment, protecting children from the worst effects of a serious temporary recession and of increasing poverty. This cushioning effect, important as it was, did not cover the full scope of children's health needs.

- The health status and risks for children since 1981 appear to be adversely affected. More time will be required for the accumulation and reporting of definitive data, but sufficient reports are available to lead reasonable policy makers to the inescapable conclusion that the health of children, pregnant women and poor families is suffering and in great jeopardy.

- The adverse effects on children's health since 1981 must be attributed to a combination of circumstances that include serious recession, increased poverty rates for households with children, and diminished health benefits and social support services. Earlier trends confirm that the public health and social programs were in fact working and that their withdrawal in the face of deepening economic recession subjected children to preventable risks to their health and well-being. These findings confirm that the health status of children is influenced by interdependent and interlocking factors that include economic well-being, access to health care and social supports.

- These findings suggest that when either local or widespread economic reversals are anticipated, health services and social supports for children need to be expanded rather than contracted. When viewed against the magnitude of total government expenditures, and the great affluence of the United States, even in the face of recession, no reasonable claim can be made that expenditures for children's programs contribute meaningfully to recession, or that withdrawing funds from the programs relieves recession.

The public policies and programs that protect pregnant women, infants and children from the devastating effects of recession and high unemployment rates are well known. The effectiveness of these measures has been demonstrated. They require expansion and reinforcement at all times, but most particularly at times of economic reversal.

Senator BENTSEN. Dr. Eaton, Dr. Budetti, I want to thank you for coming to Washington and seeing this city in its full fall glory. I am pleased to hear from both of you. We will begin with Dr. Eaton who will discuss the MCH and its predecessor, the old title V programs.

STATEMENT OF ANTOINETTE PARISI EATON, M.D., PROFESSOR OF PEDIATRICS AND PREVENTIVE MEDICINE, OHIO STATE UNIVERSITY, AND ASSOCIATE MEDICAL DIRECTOR, AMBULATORY SERVICES, COLUMBUS CHILDREN'S HOSPITAL

Dr. EATON. Mr. Vice Chairman, I am delighted that I have been given an opportunity to appear before the Joint Economic Committee to testify concerning the effectiveness of the title V maternal and child health block grant—MCH block grant—programs and their cost benefits. I bring several different perspectives to this task.

From 1974 until 1980 I was chief of the Division of Maternal and Child Health of the Ohio Department of Health which is responsible for the administration at the State level of the MCH block grant programs. I am currently professor of pediatrics and preventive medicine at Ohio State University and associate medical director, ambulatory services, at Columbus Children's Hospital.

I am also chairman of the Ohio Chapter of the American Academy of Pediatrics; chairman of the Academy's National Committee on Community Health Services; and chairman of the Academy's Project Advisory Committee for the United States-Mexico Border project.

I would like to submit my prepared statement for the record and I would like to briefly summarize the rest of my testimony at this time.

Title V of the Social Security Act was originally enacted in 1935 and provided Federal grants in aid to the State for a maternal and child health program and a crippled children's program, as well as Federal discretionary funding of special demonstration and training projects of regional and national significance.

The maternal and child health block grant legislation enacted in 1981 consolidated these programs with other maternal and child health programs under title V. It should be noted that the title V MCH block programs and the title XIX medicaid program are complementary although the funding for the former is very small as compared with the funding for the latter.

As you are well aware, medicaid is a medical insurance program which created a reimbursement mechanism designed to permit financial access in health care by low-income individuals including mothers and children, and the Federal Government reimburses States for a proportion of medical care expenditures for individuals on public welfare, although States can elect to cover under a medically needy program the medically needy who are not receiving public welfare but whose income in relation to medical care needs is low enough to require assistance.

In contrast, title V MCH block grant is, in essence, a Federal grant-in-aid public health program with a broad intent of promoting the health of all mothers and children including handicapped children. The title V MCH programs have the mandate of planning and developing a system of health care for mothers and children; assessing the

health care needs of this population; and targeting resource in accordance with those needs.

They are responsible for introducing innovative and optimal methods of health care into the system for mothers and children, and evolve standards with respect to the quality of medical services provided to mothers and children.

Thus, the title V programs have played an important role in the development of an infrastructure within which health care providers furnish care to title XIX-eligible pregnant women and children.

Furthermore, title XIX program eligibility requirements are sufficiently stringent so as to exclude significant proportions of the population of mothers and children who are in need of health services, but lack the financial resources to obtain these services or who are at the greatest risk for bad health outcomes, or both.

And the title V programs provide services to a substantial number of such mothers and children. For example, the title V programs are the primary source of services for the so-called working poor mothers and children who have lost private health insurance due to family unemployment but who are not eligible for the title XIX programs.

Still another example is the coverage of title V programs of handicapped and chronically ill children from families who would not be otherwise classified as low income and are ineligible for title XIX coverage, but who lack the financial resources to pay for the often very costly care such children require.

Turning to the impact of title V maternal and child health block programs, I wish to state at the outset my appreciation to the National Maternal and Child Health Resource Center which furnished me with materials regarding the impact of the MCH block grant programs and assisted me in the preparation of my testimony.

All States utilize formula funds received under title V MCH block grant programs to provide a variety of services for pregnant women and infants which generally include prenatal care, hospitalization for high risk pregnant women, postnatal clinics and neonatal intensive care for high risk infants.

The State title V MCH programs have had and continue to have as a high priority better prenatal care for pregnant women. Without prenatal care, a pregnant woman is more likely to have a low-birthweight child, which is the most important predictor of death or illness.

Senator BENTSEN. We will have a low what? I did not hear that.

Dr. EATON. Without prenatal care, a pregnant woman is more likely to have a low-birthweight child, which is the most important predictor of death or illness in early infancy.

An excellent illustration of the effectiveness of comprehensive prenatal care furnished through projects supported with title V MCH block grant funds are the maternal and infant care projects, the so-called MIC project, which are targeted to low-income pregnant women and infants in particularly underserved areas of the State which have been the subject of several evaluations.

The largest and most methodically sound published studies of the effectiveness of an MIC project is the study of effectiveness of prenatal support services provided by the Cleveland, Ohio, MIC project which was supported with title V funds.

This study was conducted by Dr. Sokol, et al., at the Cleveland Metropolitan General Hospital. In this study, the outcomes of pregnancy for both the mother and infant of MIC project patients were compared with the outcomes of pregnancy for a comparable risk population of pregnant women in Cleveland who did not receive prenatal care through the project.

The results of this study indicate that the MIC project patients experienced 60 percent lower perinatal mortality than the control groups. Both groups were patients in the same hospital and were delivered by the same doctors. The inherent difference between the groups was that one group received prenatal and some other services through the MIC project, and the other group received routine care from the city clinic of the same hospital.

While there are very few studies on the cost benefits of comprehensive prenatal care of the sort offered by MIC projects and similar projects, the data that are available are very encouraging. Perhaps the cost extensive and sophisticated study of the cost benefit of this kind of project is an evaluation of the California obstetrical access project presently being conducted by the Institute for Health Policy Studies at the California Department of Health.

The California OB access project, which was supported with title V formula funds, was a pilot project operating from and providing comprehensive prenatal care in several different geographical areas with several different service delivery mechanisms.

This study, thus far, has compared the pregnancy outcomes of pregnant women in the OB access project from 1979 to 1982, with an equal number of matched control pregnant women enrolled in the California title XIX medicaid program, Medi-Cal.

The study found that OB access patients had fewer lower birthweight babies than the medicaid enrollees. California has approximately 110,000 births to low-income women per year and if all these women had access to the type of comprehensive prenatal care furnished by the OB access project the preliminary results of the study indicate that $49 million in savings would accrue to the State because access to this care would produce a reduction in low-birthweight babies which would, in turn, decrease in needed hospitalization of such babies through the first year of life.

Moreover, there would be additional savings due to the fact that there would be a lower incidence of severe developmental delay which would, in turn, reduce the institutionalization of children with severe development delay associated with low birthweight.

In addition to the already described studies, there are other studies which demonstrate the cost effectiveness of title V MCH block grant programs which provide services to pregnant women and infants. Suffice it to say that I believe it has been documented that these programs have been highly successful.

The programs consolidated in the MCH block grant have also made possible a wide variety of programs which provide primary health care for children.

The immunization of children against infectious diseases, which can cause permanent disability, and in some cases death, constitutes one of the greatest successes of federally funded State child health serv-

health care needs of this population; and targeting resource in accordance with those needs.

They are responsible for introducing innovative and optimal methods of health care into the system for mothers and children, and evolve standards with respect to the quality of medical services provided to mothers and children.

Thus, the title V programs have played an important role in the development of an infrastructure within which health care providers furnish care to title XIX-eligible pregnant women and children.

Furthermore, title XIX program eligibility requirements are sufficiently stringent so as to exclude significant proportions of the population of mothers and children who are in need of health services, but lack the financial resources to obtain these services or who are at the greatest risk for bad health outcomes, or both.

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An excellent illustration of the effectiveness of comprehensive prenatal care furnished through projects supported with title V MCH block grant funds are the maternal and infant care projects, the so-called MIC project, which are targeted to low-income pregnant women and infants in particularly underserved areas of the State which have been the subject of several evaluations.

The largest and most methodically sound published studies of the effectiveness of an MIC project is the study of effectiveness of prenatal support services provided by the Cleveland, Ohio, MIC project which was supported with title V funds.

ices and large-scale immunization campaigns have virtually eliminated smallpox and led to marked declines in the incidence of diphtheria, measles, whooping cough, polio, rubella, and tetanus. Title V MCH moneys have been widely used by States to fund the immunization activities of public health nurses.

One of the best illustrations of the beneficial impact of the MCH block grant programs which deliver health care to children are the children and youth projects which are targeted to low-income children in underserved areas. In my own State of Ohio there are two C&Y projects, one in Columbus and one in Dayton, and I am currently directly involved in the planning and administration of the Columbus project.

A good example of an evaluation of cost benefits of C&Y projects is furnished by an evaluation of the New York City C&Y projects. For example, New York City at the present time has seven C&Y projects which provide comprehensive preventive diagnostic and treatment services for low-income children rather than fragmented health services for episodic illnesses.

The effectiveness and cost benefits of these projects is demonstrated by the fact that children enrolled in the C&Y projects have fewer hospitalizations and lower pharmacy costs than medicaid-eligible children in New York City as a whole using traditional health services. In 1980, the C&Y children had a 30-percent lower hospitalization rate than medicaid-eligible children in New York City as a whole, and the pharmacy costs for the C&Y patients were one-quarter of those for medicaid-eligible children in New York City as a whole.

In 1980, the New York City C&Y project, together with the maternity and infant care project, had annual savings of approximately $21 million plus in two selected areas alone and prevented hospitalizations and lower pharmacy costs. In 1980 these projects received approximately $11½ million in title V funds. Thus, the 1980 cost savings realized by these projects were twice the amount of the title V funding allocated to them.

Several of the programs consolidated in the MCH block grant, such as the State crippled children's programs and the State supplemental security income for blind and disabled children programs, provide or assist in the provision of services for children with handicapping conditions, life-threatening or chronic diseases, and mentally retarded children. In addition, there are several programs—such as the pediatric pulmonary centers, the university-affiliated programs for the developmentally disabled, and the hemophilia programs—which are a major source of services for handicapped chronically ill and mentally retarded children.

Probably the most extensive study of the impact of a program supported with MCH block grant funds is that involving a 5-year study of outcomes of comprehensive hemophilia diagnostic and treatment center programs. The regional hemophilia centers provided state of the art comprehensive services including not only medical, dental, and orthopedic care, but also psychosocial and vocational counseling furnished by multidisciplinary teams.

Prior to the establishment of these centers, care received by hemophiliacs tended not to be comprehensive and was often uncoordinated.

A 5-year study of the outcomes of 11 of the centers provided dramatic evidence of their effectiveness.

Thus, these centers have resulted in the reduction of the average number of days spent by hemophiliacs in the hospital each year, a reduction in the number of days lost to school and to work each year, and a reduction in their unemployment.

The cost benefits of the hemophilia centers are also dramatic. Studies have documented a 62-percent reduction in total health care costs per patient. That is, $15,800 per year in 1975 to $5,932 in 1981. This represents an annualized savings of $93.7 million?

This savings was achieved by a program that cost the Federal Government $2.6 million during fiscal year 1983.

Just as the hemophilia centers have had a beneficial impact, other title V MCH block grant programs for the handicapped, chronically ill and mentally retarded children have been effective in prolonging their lifespan, decreasing their hospitalization, and improving their overall ability to function at home and school.

Among the programs consolidated in the MCH block grant was the genetic diseases program. The genetics projects have been the source of newborn screening programs in many States under which infants are screened for various genetic diseases.

In addition, there are a number of genetics projects supported with MCH block grant funds which provide genetic counseling to families with potential problems and provide genetic education and training to professionals in the health field and related fields.

The genetics projects I can say personally have been very successful. For example, newborn programs, screening programs have provided a low-cost screening and testing for infants with phenylketonuria for whom a dietary change will mean the difference between normal functioning and mental retardation.

A 1977 General Accounting Office report to Congress found that the cost of screening at birth plus early treatment for seven common disorders was less than one-eighth the projected cost of caring for an impaired child over a lifetime.

In summary, programs supported with Federal MCH block grant funds are highly effective and have very real cost benefits. I would like to stress, however, that while these programs have done much to improve the health status of mothers and children, including handicapped children, much remains to be done.

Unfortunately the limited Federal funding which is currently available for these programs has meant that they must struggle to fulfill their mandate to promote the health status of mothers and children, and that they cannot assist many mothers and children in need of services to obtain such services.

I would like to end on a personal note by expressing to you my most sincere thanks for your interest and support, and your efforts on behalf of mothers and children; and I say this on a personal level, perhaps, more than a professional one since I am the mother of four children. Thank you.

[The prepared statement of Dr. Eaton follows:]

Prepared Statement of Antoinette Parisi Eaton, M.D.

Mr. Chairman, I am delighted that I have been given an opportunity to appear before the Joint Economic Committee to testify concerning the effectiveness of the Title V Maternal and Child Health Block Grant (MCH Block Grant) programs and their cost benefits. I bring several different perspectives to this task. From 1974 until 1980 I was Chief of the Division of Maternal and Child Health of the Ohio Department of Health which is responsible for the administration at the state level of the MCH Block Grant programs. I am currently Professor of Pediatrics and Preventive Medicine at Ohio State University and Associate Medical Director, Ambulatory Services, at Columbus Children's Hospital. I am also Chair of the Ohio Chapter of the American Academy of Pediatrics, Chair of the Academic National Committee on Community Health Services, and Chair of the Academy's Project Advisory Committee for the United States-Mexico Border Project.

BACKGROUND

Title V of the Social Security Act was originally enacted in 1935 and provided federal grants-in-aid to the states for a maternal and child health program and a crippled children's program, as well as federal discretionary funding of special demonstration and training projects of regional and national significance. The Maternal and Child Health Block Grant legislation, enacted in 1981, consolidated these programs with other maternal and child health programs under Title V.

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It should be noted that the Title V MCH Block programs and the Title XIX Medicaid program are complementary, although the funding of the former is very small as compared with the funding for the latter. As you are well aware, Medicaid is a medical insurance program which created a reimbursement mechanism designed to permit financial access and health care by low-income individuals including mothers and children, and the federal government reimburses states for a proportion of medical care expenditures for individuals on public welfare, although states can elect to cover under a Medicaid medically needy program the medically needy who are not receiving public welfare, but whose income in relation to medical care needs is low enough to require assistance.

In contrast, Title V MCH Block Grant is in essence a federal grant-in-aid public health program with the broad intent of promoting the health of all mothers and children including handicapped children. The Title V MCH programs have the mandate of planning and developing a system of health care for mothers and children, perform the function of assessing the health care needs of mothers and children and targeting resources in accordance with those needs, and introduce innovative and optimal methods of health care into the system of health care for mothers and children. Thus, the Title V programs have played an important role in the development of an infra-structure within which health care providers furnish care to Title XIX eligible pregnant women and children. In addition, the Title V programs have evolved standards with respect to the quality of medical services provided mothers and children which not only govern the provision of these services in Title V programs, but also can serve as a reference point for the Title XIX programs.

Moreover, Title XIX program eligibility requirements are sufficiently stringent so as to exclude significant proportions of the population of mothers and children who are in need of health services, but lack the financial resources to obtain these services, or who are at the greatest risk for bad health outcomes or both, and the Title V programs provide services to a substantial number of such mothers and children. For example, the Title V programs are the primary source of services for the so-called working poor who are not eligible for the Title XIX programs. Another example is the coverage of the Title V programs of many mothers and children who have lost private health coverage due to family unemployment, but who are not eligible for the Title XIX programs. Still another example is the coverage of Title V programs of handicapped and chronically ill children from families who would not be classified as low-income and are ineligible for Title XIX coverage, but who lack the financial resources to pay for the often very costly care such children require.

Furthermore, the Title XIX Medicaid program has tended to emphasize acute care services which are hospital-based, although the Medicaid Early Periodic, Screening, Diagnosis and Treatment (EPSDT) program is aimed at ensuring that Medicaid eligible children receive preventive care. However, the traditional focus of many of the MCH Block Grant programs has been the improvement of preventive care, and these programs have been heavily involved in multi-disciplinary support services and outreach.

Finally, it should be noted that Title V MCH Block Grant programs have a series of interrelationships with not only the Title XIX Medicaid, but also other federal programs, and the Title V MCH Block Grant programs are complementary to the Women, Infants and Children

Nutrition (WIC) program, the Title X Family Planning program, the Developmental Disabilities program and federally supported special education programs.

IMPACT OF MATERNAL AND CHILD BLOCK GRANT PROGRAMS

Turning to the impact of Title V MCH Block Grant programs, I wish to state at the outset my appreciation to the National Maternal and Child Health Resource Center which furnished me with materials regarding the impact of the MCH Block Grant Programs and assisted me in the preparation of this testimony.

Impact of Title V MCH Block Grant Services for Pregnant Women and Newborns

All states utilize formula funds received under Title V MCH Block Grant programs to provide a variety of services for pregnant women and infants which generally include prenatal clinics, hospitalization for high risk pregnant women, postnatal clinics and neonatal intensive care for high risk infants. The state Title V MCH programs have had and continue to have as a high priority better prenatal service for pregnant women. The lack of adequate prenatal care is closely associated with increased stillbirths, increased prematurity rates and increased newborn mortality and morbidity. Without prenatal care, a pregnant woman is more likely to have a low birth weight child which is the most important predictor of death or illness in early infancy.

A landmark study of all births in New York City in 1968 showed that death rates of infants born to mothers in each of several categories of risk were lowest among infants whose mothers had adequate prenatal care, slightly higher if their mothers had intermediate care and the highest

if the mothers had inadequate care. Mothers who began their prenatal care in the first eleven weeks of pregnancy and had at least nine visits had an infant mortality rate of 6.0 per 1,000, compared to a rate more than 3 times as high (19.0 per 1,000) for women who delayed their first visit until the 28th week or later and had fewer than 5 visits. The researchers concluded that "generally, adequacy of care . . . is strongly and consistently associated with infant birth weight and survival, an association that is pronounced throughout the entire first year of life."

An excellent illustration of the effectiveness of comprehensive prenatal care furnished through projects supported with Title V MCH Block Grant funds are the "maternal and infant" care projects (MIC projects) which are targeted to low-income pregnant women and infants in particularly underserved areas of the state. The MIC projects and projects utilizing the MIC model have been the subject of several evaluations.

The largest and most methodically sound published study of the effectiveness of a MIC project is a study of effectiveness of prenatal support service provided by the Cleveland, Ohio MIC Project, which was supported with Title V funds. This study was conducted by Doctor Sokol, et. al, at the Cleveland Metropolitan General Hospital. Since I was Chief of the MCH Division of the Ohio Department of Health, I was directly involved in the administration and development of this project, and I, of course, am familiar with the study.

In this study the outcomes of pregnancy (for both the mother and infant) of MIC project patients were compared with the outcomes of pregnancy for a comparable risk population of pregnant women in Cleveland who did not receive prenatal care through the project.

Results of this study indicate that the MIC Project patients experienced 60% lower perinatal mortality than the control groups. Both groups were patients in the same hospital and were delivered by the same doctors. The inherent difference between the groups was that one group received prenatal and some other services through the MIC project and the other group received routine care from the city clinic of the hospital.

While there are very few studies on the cost benefits of comprehensive prenatal care of the sort offered by MIC projects and similar projects, the data that are available are very encouraging. Perhaps the most extensive and sophisticated study of the cost benefits of this kind of project is an evaluation of the California Obstetrical Access Project presently being conducted by the Institute for Health Policy Studies for the California Department of Health Services. The California OB Access Project which was supported with Title V MCH formula funds, was a pilot project operating from 1979-1982 and providing comprehensive prenatal care, including health services, nutrition counselling and psycho-social counselling, some delivery care, and some post-partum care in several different geographical areas utilizing several different service delivery mechanisms.

The aforementioned study has thus far compared the pregnancy outcomes of pregnant women in the OB Access project from 1979-82 with an equal number of matched control pregnant women enrolled in the California Title XIX Medicaid program (Medi-Cal). The study found that the low birth weight rate for the OB Access patients was 4.52%; whereas the low birth weight rate of the Medicaid enrollees was 7.19%. With the observed improvement of the low birth weight distribution, there would be a decreased incidence of the need for neonatal intensive care and rehospitalization for newborns among OB Access patients. Likewise, with

the observed improvement of the low birth weight distribution, there would be a decreased incidence of children with severe developmental delay, which would in turn produce a reduction in the institutionalization of children with severe developmental delay.

The preliminary results of the study indicate that for every dollar spent on the California OB Access project, at least $4.20 to $5.80 are saved due to decreased cost for hospitalization of low birth weight babies during the first year of life and the decreased cost of institutionalization for low birth babies who as children suffer from severe development delay. California has approximately 110,000 births to low-income women per year, and if all these women had access to the type of comprehensive prenatal care furnished by the OB Access Project, it is estimated that $49 million dollars in savings would accrue to the state because access to this care would produce a reduction in low birth babies which would in turn produce a decrease in needed hospitalization of such babies through the first year of life. Moreover, there would be additional savings due to the fact that there would be a lower incidence of severe developmental delay associated with low birth weight.

In addition to the already described studies, there are other studies which demonstrate the cost-effectiveness of Title V MCH Block Grant programs which provide services to pregnant women and infants. Suffice it to say that I believe it has been documented that these programs have been highly successful.

Impact of MCH Block Grant Services for Children

The programs consolidated in the MCH Block Grant have also made possible a wide variety of programs which provide primary health care

for children. According to the Report of a Select Panel to Promote Child Health, the value of comprehensive health care for children in laying a basis for lifelong health "is clear," and children are uniquely fortunate in the range of preventive services available to them.

The immunization of children against infectious diseases, which can cause permanent disability and in some cases death, constitutes one of the greatest successes of federally funded state child health services, and large-scale immunization campaigns have virtually eliminated smallpox and led to marked declines in the incidence of diphtheria, measles, whooping cough, polio, rubella and tetanus. Title V MCH monies have been widely used by states to fund the immunization activities of public health nurses.

One of the best illustrations of the beneficial impact of the MCH Block Grant programs which deliver health care to children are the Children and Youth Projects (C&Y Projects), which are targeted to low-income children in underserved areas. In my own state of Ohio there are two C&Y projects, one in Columbus and one in Dayton, and I am currently directly involved in the planning and administration of the Columbus project.

A good example of an evaluation of cost benefits of C&Y projects is furnished by an evaluation of the New York City C&Y projects. For example, New York City at the present time has seven C&Y projects which provide comprehensive, preventive diagnostic and treatment services for low-income children rather than fragmented health services for episodic illnesses. In 1980 approximately 52% of the patients had incomes less than or equal to 150% of the federal poverty level and 40% were Medicaid eligible.

The effectiveness and cost benefits of these projects is demonstrated by the fact that children enrolled in the C&Y projects have fewer hospitalizations and lower pharmacy costs than Medicaid-eligible children in New York City as a whole using traditional health services. In 1980, the C&Y children had a 30% lower hospitalization rate than Medicaid-eligible children in New York City as a whole, and the total cost of providing services to a child in a C&Y for one year is approximately the cost of one day's hospitalization through Medicaid. The pharmacy costs for C&Y patients were one-quarter of those for Medicaid-eligible children in New York City as a whole.

In 1980 the New York City C&Y projects together with the Maternity and Infant Care project had annual savings of approximately $21,352,384 in two selected areas alone -- and prevented hospitalizations and lower pharmacy costs. In 1980 these projects received $11,660,181 in Title V funds. Thus, the 1980 cost savings realized by these projects were twice the amount of the Title V funding allocated to them.

Impact of MCH Block Grant Services for Handicapped Children

Several of the programs consolidated in the MCH Block Grant, such as the State Crippled Children's (CC) programs and the State Supplemental Security Income for Blind and Disabled Children (SSI) programs provide or assist in the provision of services for children with handicapping conditions, life-threatening or chronic diseases and mentally retarded children. And all states allocate a significant amount of the formula funds they receive under the MCH Block Grant to these programs. In addition, there are several programs such as the pediatric pulmonary centers, the universally affiliated programs for the

developmentally disabled and the hemophilia programs which are a major source of services for handicapped, chronically ill and mentally retarded children.

Such children often require highly specialized health care as well as other services such as special education services and social services. Furthermore, the care which such children require often involves professionals from many disciplines and is quite expensive because of its specialized nature.

Probably the most extensive study of the impact of a program supported with MCH Block Grant funds is that involving a five-year study of outcomes of comprehensive hemophilia diagnostic and treatment center programs. In 1975, Congress established the comprehensive hemophilia diagnostic and treatment program to establish regional hemophilia centers and affiliates. In 1981 this program was consolidated with other programs in the MCH Block Grant and was made eligible for funding with the 10-15% of the federal appropriation set-aside for discretionary funding of projects of regional and national significance.

The regional hemophilia centers provide state of the art comprehensive diagnostic and treatment services, including not only medical, dental and orthopedic care, but also psycho-social and vocational counseling furnished by multi-disciplinary teams. Prior to the establishment of these centers, care received by hemophiliacs tended not to be comprehensive and was often uncoordinated.

A five-year study of the outcomes of eleven of the centers provided dramatic evidence of their effectiveness. Between 1975 and 1981 the following occurred:

- The number of patients served by the centers more than tripled and more than two-thirds of the patients can treat themselves when needed.
- The average number of days spent by these patients in the hospital per year was reduced from 9.4 days to 1.8 days.
- The number of days lost to work or school each year because of bleeding decreased four-fold.
- Unemployment decreased from 36% of the patients during the year prior to federal funding of these centers to 13% and as low as 4.5% in New England.
- The number of patients with third-party coverage increased from 74% to 93%.
- The out-of-pocket expenses per patient per year have decreased from $850.00 to $340.00 per year.

The cost-benefits of the hemophilia centers are also dramatic. Studies have documented a 62% reduction in total health care costs per patient ($15,800 per year in 1975 to $5,932 in 1981). This represents an annual savings of $93.7 million dollars. This saving was achieved by a program that cost the federal government $2.6 million dollars during FY 1983.

Just as the hemophilia centers have had a beneficial impact, other Title V MCH Block Grant programs for handicapped, chronically ill and mentally retarded children have been effective in prolonging their life span, decreasing their hospitalization, and improving their overall ability to function at home and school. Moreover, just as the hemophilia centers have very real cost benefits, other Title V Block

Grant programs for handicapped, chronically ill and mentally retarded children have produced cost savings.

Genetic Services for Families

Among the programs consolidated in the MCH Block Grant was the Genetic Diseases Program. Under this program the Federal Division of Maternal and Child Health has made discretionary grants for genetics projects. These projects have been the source of newborn screening programs in many states under which infants are screened for various genetic diseases. In addition, there are a number of genetics projects supported with MCH Block Grant funds which provide genetic counseling to families with genetic problems or potential problems and provide genetic education and training to professionals in the health field and related fields. MCH Block Grant programs providing genetics services furnish a link between the MCH Block Grant Programs dealing with maternal and child health services and the MCH Block programs dealing with health services for handicapped, chronically ill and mentally retarded children, because if genetic services can be incorporated into the primary health care of mothers and children, many handicapping conditions from which children suffer could be prevented.

For example, newborn screening programs result in the identification of genetic diseases which if undetected and improperly managed can lead to mental retardation and other handicapping conditions. Thus, newborn screening programs have provided low-cost screening tests for infants with phenylketonuria (PKU) for whom a dietary change will mean the difference between normal functioning and mental retardation. Screening tests for congenital hypothyroidism have

similarly been successful and cost-effective. A 1977 General Accounting Office Report to Congress found that the cost of screening at birth plus early treatment for seven common disorders was less than one-eighth the projected cost of caring for an impaired child over a lifetime.

SUMMARY

In summary, programs supported with federal MCH Block Grant funds are highly effective and have very real cost benefits. I would like to stress, however, that while these programs have done much to improve the health status of mothers and children, including handicapped children, much remains to be done. Unfortunately the limited federal funding which is currently available for these programs has meant that they must struggle to fulfill their mandate to promote the health status of mothers and children and that they cannot assist many mothers and children in need of services to obtain such services.

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Senator BENTSEN. Thank you very much, Dr. Eaton.

As I was listening to your testimony, I could not help but think that even if a person had absolutely no emotions, no personal involvement with these children—even if they had not personally experienced some of these problems in their own family—that just by looking at the studies you cite, an overwhelming case exists in support of the expenditures in this area. It ought to impress even a David Stockman.

Dr. EATON. Let us hope so.

Senator BENTSEN. But you know there is much more to the story than just some numbers. You are talking about lifetime handicaps that come from inadequate prenatal care or childhood immunizations.

What we have to remember here is that as we try to shrink these runaway deficits, one of the priorities has to be to maintain our investment in human assets and what they mean to a productive country in the years to come.

I appreciate your testimony. I have some questions I want to ask you later, but at this point I would like to proceed with Dr. Budetti, if you would give us your testimony, please.

STATEMENT OF PETER P. BUDETTI, M.D., J.D., ASSOCIATE PROFESSOR OF SOCIAL MEDICINE IN PEDIATRICS, INSTITUTE FOR HEALTH POLICY STUDIES AND DEPARTMENT OF PEDIATRICS, SCHOOL OF MEDICINE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Dr. BUDETTI. Thank you very much, Senator Bentsen. And, like Dr. Eaton, I am pleased to be here to be able to share my thoughts with you and also, like Dr. Eaton, I am gratified that you have recognized the importance of these issues, the importance of addressing child health problems, and that you have chosen to devote so much of your own time and efforts to the solution of these problems.

Far too often we hear the question raised: "Why should we even worry about children?" Now, to many people, particularly those of us with firsthand experience in the delivery of health care, the reasons for special concern for children are self-evident: to insure that we can relieve pain and suffering, avoid unnecessary deaths, and help all children achieve their maximum potential.

But as you pointed out just a minute ago, beyond those arguments there is a very real argument that child health is a social investment and also, as you pointed out earlier, children are vulnerable politically and need adults to speak for them.

Finally, as Dr. Eaton just touched upon, there is a need for specialized health services that, in many cases, are as unique as the children they treat. In terms of the societal value of healthy children, health is very important in determining both the kinds of schools children can attend and their performance in school.

Poor health seriously affect their ability to work in the future, a particularly important societal value. As the Nation has more older people, we will need more productivity from all of our younger people and the healthier they are, the more productive they are likely to be.

In terms of political vulnerability, I think we have all seen many implications in the health care field. One of the most important ele-

ments is that we have evolved a health care system based on employment for adults and on medical care for the aging; and, therefore, we have a system that is not targeted specifically toward children's needs.

So it is not surprising that we have more incentives to provide highly technical services for adults and long-term care for the aged than preventive and primary care services for children.

Finally, on the question of specialized health services, we all know of, and of course we are very grateful for, the gains that have been made in child health in recent years. It is remarkable that most children are quite healthy and need principally preventive and acute care.

But some groups of children are very sick. We are going to be talking about the poor children, in particular. There are also children whom you remarked on, the relatively small proportion of children with chronic handicapping conditions that require a large amount of highly specialized health care, and it is important to remember that we cannot treat those children medically as small adults. We are talking about children with afflictions such as extreme prematurity, spinal bifida, cystic fibrosis, metabolic diseases, physical handicaps, and a myriad of other serious chronic health conditions.

These conditions are very rare. Each of them requires unusual medical expertise. Taken together, children with these kinds of conditions are only a small fraction of all children, but they require virtually a third of all health care resources consumed by children.

So I believe that there are compelling reasons to be concerned about children.

Thinking about the second question: Why worry about poor children? I think there is a very simple answer: Poor children are sicker and poor children are dependent on public programs for health care.

Illness is more common among poor children and, even more strikingly, is more severe when it occurs. Clinical and epidemiological studies indicate that poor children are twice as likely to be born at low birthweight, twice as likely to contract illnesses such as bacterial meningitis, three to four times as likely to lack indicated immunizations in the preschool period, two to three times as likely to contract illnesses such as rheumatic fever, two to three times as likely to have iron deficiency anemia, two to three times as likely to have hearing problems, 50 percent more likely to have uncorrected vision difficulties, nine times as likely to have elevated blood lead levels, and 75 percent more likely to be admitted to a hospital in a year. This long list of problems keeps children restricted to hospitals and causes them to lose days at school. Mortality rates, not just illness rates, are much higher among poor children. That includes the newborn period, the first year of life, in early childhood as well as in later childhood. Poor children die more often from accidents, from conditions such as leukemia and prenatal problems, and they suffer from a variety of other afflictions likely to increase mortality rates throughout childhood.

Another serious dimension to the association between low-income reported health in childhood is that the numbers of poor children are increasing, reversing the trend of recent decades. Throughout the 1960's, the rate of children under 18 years living in poverty fell by nearly one-half, from about 27 percent in 1959 to what has thus far proved to be an alltime low of 13.8 in 1969. During the 1970's, the rate fluctuated

somewhat but generally rose, reaching 16 percent in 1979. Increases since then have been dramatic: 17.9 percent in 1980; 19.5 percent in 1981; and over 21 percent in 1982. That figure means that some 1 out of every 5 children in the United States lives in poverty or some 13.5 million children.

The current situation, I believe, is clear. Poor children are not as healthy as other children; and every day there are more and more children living in poverty. Thus there is an urgent need for government to prevent, reduce, and treat the health problems of poor children.

Now, some critics have asserted that health care may not make much difference in health status. Our experience with studies of the impact of health care on the health status of children in this country, particularly children from low-income families, is quite different. It indicates that medical care can and does make a difference.

In a recent review of such literature, 26 areas were found that showed that medical care made kids healthier. Not all the evidence is perfect. We do not put a lot of money into studies of this kind, but it is clear to many of us that the studies are sound enough and conclusive enough that child health is well benefited by medical care programs.

Now, looking at medicaid in particular, it is dramatic how the gaps in access to care have begun to close. Although disparities still exist, utilization of health care services by poor children is now about the same as for nonpoor children.

In 1963, before the enactment of the medicaid program, differences in utilization of health care services were great. Only about 52 percent of the younger children and 41 percent of older children in low-income families had seen a physician in the previous year compared with 87 percent and 70 percent respectively in higher income groups.

Since that time, those numbers have been reversed and the numbers are much closer now. Medicaid has greatly improved access for low-income children. There are still disparities, particularly in getting children to have a regular source of care so they know where they are going for their care and having a regular personal physician to provide that care.

Programs such as medicaid have not only helped children get to the doctor and get into the hospital when they need it, they have also helped improve the health status of those children; and my prepared statement cites the number of studies that point toward the impact of medicaid on improving the health status of low-income children.

Now, it is important, I think, to remind ourselves that not only can medicaid make a difference, but also that medicaid is overwhelmingly the most important means for providing health care to poor children.

The Federal Government does not spend many medicaid dollars, but what it does spend is critical. The money is a small proportion in the absolute amount of Federal expenditures, but it is very important for children. Medical accounts for 55 percent of public funds spent for children. The aged and other groups have other sources of health insurance, particularly medicare; but low-income children are really heavily reliant on the medicaid program.

Recent studies released by the Census Bureau document the importance of medicaid for these children. In 1981, if you look at the chil-

dren who live below the poverty level, two-thirds had only medicaid; private insurance could be counted on for only 18 percent of these children. Because many families under the poverty level have no health insurance—without medicaid—nearly four of five children of these families would have no health insurance protection whatsoever.

Medicaid unfortunately leaves some gaps. These are gaps that need to be filled. Medicaid has historically covered fewer than half the children living below the poverty level. As the number of poor children increase in this country, we would expect to see a significant rise in the number of medicaid recipients who are children.

Unfortunately, in the last couple years, this has not happened and I believe we will hear testimony later from the Children's Defense Fund citing figures as high as 700,000 women and children removed from the medicaid health rolls, a consequence of the fact that States control the financial standards for welfare programs. When those standards are not increased over time, only poor and poorer people are eligible for medicaid. In addition, the fact that medicaid is limited to children in certain categories restricts eligibility.

One of the most important and one of the most unfortunate policies, of course, has been for States to deny coverage for prenatal care to pregnant women carrying their first child. I believe that the steps that you and others have taken to undo this unfortunate policy will be very important because of the high personal and societal costs that result from lack of prenatal care. Clearly there is an association between providing cost-effective prenatal care and reducing the number of low-birthweight infants whose care is so expensive.

Another important group of children left out of the medicaid program in many States are the medically needy, such as children from families in the right categories, but with income categories just a little bit too high; even when their families have huge medical bills, they may not be eligible for medicaid. Twenty States still do not cover medically needy children as of 1983.

Cuts directly affect other State programs and private expenditures to health care as well.

Dr. Eaton mentioned the Crippled Children's Services [CCS]. For many years they have been able to target their funds on ambulatory services and on specialized services because many of the CCS children were also eligible for medicaid. But as medicaid is cut back, the CCS programs may well have to devote an increasing share of their budgets to the in-hospital care once funded by the medicaid program, thus severely restricting their ability to deliver the specialized and cost-effective services that Dr. Eaton referred to.

Private sector medicaid cutbacks in eligibility benefits and payment levels increase the bad debt levels that hospitals and physicians see leading to cost shifting to private patients, making in affect, a hidden tax on employers and on sick people who have health insurance and/or pay out of their own pockets.

The deleterious effects of medicaid restrictions on children have by no means all been measured as yet and many may not appear for years. Dr. Miller cites some indications of the ill effects of program cutbacks over the last couple of years along with the recession. I have some preliminary results from a study of pediatricians who mainly work in teaching clinics.

The study was conducted earlier this year and shows the impact of medicaid cuts on other programs. Of the nearly 400 pediatricians who responded to the survey, two out of three reported a need to cut back services in their programs because of cuts in public programs; almost half of the reported reductions were due to problems with medicaid.

About one-third of those pediatricians reported an increased use of their clinics by people who previously sought care elsewhere but now were unable to pay for care. They also cited a large number of families without insurance now unable to afford treatment who had previously been going somewhere else.

In conclusion, I would like to say that medicaid is by far the most important program the Federal Government has ever established for health care needs of poor children. It has opened the door to care for many children. Many other poor children—more than half—were never covered, however, because their numbers are increasing. We know there are reforms which may be necessary—controls on spending increases may be necessary—but not ones that deny medical care to children in poverty.

I strongly support the position of the American Academy of Pediatricians that all children have a right to health care and that children should be covered by a comprehensive public plan when families are unable to provide for adequate health financing. This should be the goal of our country and we should move toward and not away from meeting that goal. Thank you very much.

[The prepared statement of Dr. Budetti follows:]

Prepared Statement of Peter P. Budetti, M.D., J.D.

Senator Bentsen and Members of the Committee, I am Peter P. Budetti, M.D., J.D., Associate Professor of Social Medicine in Pediatrics of the Institute for Health Policy Studies and the Department of Pediatrics of the University of California, San Francisco. I appreciate your invitation to share with you my thoughts about Medicaid and child health. While I gratefully acknowledge the contributions of the work of many of my colleagues to this statement, my remarks are my own views and I do not purport to speak on behalf of them or the University of California.

Why Worry About Children?

To many, particularly those of us who have first-hand experience in the delivery of child health services, the reasons for a special concern over child health care are self-evident: to ensure that our ability to relieve pain and suffering, avoid unnecessary deaths, and help children achieve their maximum potential does not decline. Beyond the level of the individual child the arguments fall into three broad categories: child health as a social investment, the political vulnerability of children, and the need for specialized health services that in many cases are as unique as the children they treat.

There is a clear societal value in healthy children. Health is of importance in determining school attendance, performance and behavior, and may seriously affect future employment. Thus efforts that improve the health of children are, in a very real sense, a long-term national investment that will pay important social dividends. The importance of this social investment will increase as demographic trends change the age distribution of the American population so that there will be fewer

children relative to other age groups (the elderly in particular). That means we will need more productivity per young person, or at least fewer young people who are nonproductive.

Common to each of the underlying reasons for promoting child health is a recognition that children will always be a constituency in need of proxy representation. Children's issues will always be debated and decided -- or even neglected and made worse -- by adults. This political vulnerability of child issues has several important ramifications with regard to health and health care policy.

Unlike most other industrialized countries, the United States has had no consistent, long-term national child health policy, and no major administrative structure in the Federal government to implement such a policy. In particular, by financing health care services predominantly through employment-related insurance and through Medicare for the aging, we have created a system that pays little deliberate attention to the needs of children. As a result it should not be surprising that our system creates more incentives for high-technology, specialized acute care of adults and the elderly than for preventive or primary care services for children.

Recent changes in the national political atmosphere have renewed fears that quickly-enacted policies designed to cut health care expenditures would erode the progress children's programs had made in the past.

Unfortunately, these fears have proved to be well grounded. Some of the advocates of the new approach genuinely do believe that child health interests will be served better through state and local than through

Federal control, and blame the shortcomings of existing programs on the inefficiency of large central governments. But what has happened, however, seems to be that the magnitude of Federal fiscal reductions has been so great and changes have occurred so swiftly that we have exploited the vulnerability of children and may have in part reversed the historical accomplishments of highly beneficial programs.

The third, and possibly most important, reason for particular concern about children is that children require specialized health care and therefore policy decisions that are based on the population as a whole can have disastrous effects when applied to certain areas of child health. Most children, as we all know, are quite healthy and need principally preventive and acute illness care. But some groups are very sick. For example, a major study analyzing the frequency of serious health problems in the first year of life revealed that infants are subject to both a high frequency and higher acuity in health problems. One in five infants suffers at least one major health problem and one in ten is hospitalized during the first year.

In addition, a relatively small proportion of the child population requires a disproportionately large and highly specialized amount of health care. These children cannot be regarded medically as "small adults." In this category are infants and children with afflictions such as extreme prematurity, spina bifida, cystic fibrosis, metabolic diseases, physical handicaps and a myriad of other serious chronic health conditions. Each one of these conditions is rare and requires unusual medical expertise. Taken together, children with chronic and disabling conditions are only a

small fraction of all children but require about one-third of all hospital care for children.

Thus there are compelling reasons to be concerned about children. Individual children need to have their pains relieved and their potential stimulated. Society needs healthy children to become healthy, productive adults. Children have no direct political power and must rely on us to represent them honorably. And children who are sick need special care that will not be available in a system designed to care for adults and the elderly.

Why Worry About Poor Children?

Family income is a powerful correlate of ill health in childhood. Illness is more common among poor children and, even more strikingly, is more severe when it occurs. Clinical and epidemiological studies indicate that poor children are twice as likely to be born at low birthweight, twice as likely to contract illnesses such as bacterial meningitis, three to four times as likely to lack indicated immunizations in the preschool period, two to three times as likely to contract illnesses such as rheumatic fever, two to three times as likely to have iron-deficiency anemia, two to three times as likely to have hearing problems, fifty percent more likely to have uncorrected vision difficulties, nine times as likely to have elevated blood lead levels, and 75 percent more likely to be admitted to a hospital in a year.

Poor children have 30 percent more days when their activity is restricted and 40 percent more days lost from school due to illness. They

are more likely to be reported by their parents as having one or more chronic conditions. Three to six times the proportion of poor children are reported by their teachers as being in fair or poor health as is the case for non-poor children and the same teachers report three times as many poor children as having a condition that limits school work or play activities. Poor children are also more likely to be diagnosed by physicians as having one or more psychosocial conditions and 40 to 50 percent more likely to be found to have a significant abnormality on physical examination by a physician than non-poor children. Family income is more strongly related to these measures of ill health than other sociodemographic characteristics such as race and parental education.

Mortality rates of poor children are much higher than is the case for non-poor children. Neonatal mortality rates are one and one-half times higher among poor children and postneonatal mortality rates are twice as high. Poor children are approximately one and one-half to three times as likely to die after the first year of life as non-poor children. The higher death rates among the poor are not due to a higher proportion of non-whites among the poor, as the discrepancies across the income groups are more consistent and striking within the white population alone. Poor children are more likely to die from accidents and from conditions such as leukemia. Perinatal problems, when they occur, have greater impact and more sequelae in poor children and poor children have greater IQ deficits when born at low birthweight than other children. Twice the proportion of poor children have marked iron deficiency and poor children are much more likely to have markedly elevated blood lead levels. Poor children with appendicitis are more likely to experience appendiceal perforation and

peritonitis than non-poor children. Poor children are two to three times as likely to have severely impaired functional vision (20/50 or worse with usual correction). The average length of stay in the hospital is twice as long for poor children and their average total hospital days are four times as high as for other children. Common conditions tend to be more severe in poor children, as is the case with asthma. Greater hospitalizations are also experienced by poor children with uncommon conditions. For example, for diabetes, the hospitalization rate is at least two to three times greater for poor than for non-poor children. Poor children are twenty times as likely as non-poor children to be unable to attend regular school because of a health-related problem and twice as likely to be limited in their ability to do so. Although evidence on the relative prognosis of health problems in poor and non-poor children is scant, data which exist suggest that the illnesses of poor children are more likely to persist or have sequelae than is the case for other children.

Thus there is compelling evidence that low income and poverty are important risk factors for childhood illness. Documentation of the mechanisms by which poverty exerts an effect is lacking but inferences can be drawn from the research literature concerning a variety of types of factors. Poor children are more likely to be exposed to environmental toxins because of the neighborhoods in which they live. Greater life stresses among poor families also predispose to greater illness. To the extent that medical care is efficacious in preventing or ameliorating illness, barriers in access to appropriate and timely care also are associated with more frequent and more severe illness.

There is another serious dimension to the association between low income and poor health in childhood -- the numbers of poor children are now increasing, reversing the trend of recent decades. Throughout the 1960s, the poverty rate among children under 18 years in families fell by nearly one-half, from 26.9% in 1959 to what has thus far proved to be an all-time low of 13.8% in 1969. During the 1970s, the rate fluctuated somewhat but generally rose, reaching 16.0% in 1979. Increases since then have been dramatic -- 17.9% in 1980, 19.5% in 1981 and over 21% in 1982. Now, some 13.6 million, more than one of every five children, lives in poverty. Furthermore, the poverty rate for children is almost 50% higher than for any other population group.

The current situation is clear -- poor children are not as healthy as other children, and every day there are more and more children living in poverty. The implications should be equally clear -- there is an urgent need for government to prevent, reduce, and treat the health problems of poor children now, even as we search for long-term solutions to the underlying poverty itself. The responsibility lies with government because of the immediacy and seriousness of illness in childhood, and particularly with the Federal government because of the great importance of Federal programs to deliver health care to poor children.

Medical Care Does Make a Difference

Although long-term declines in mortality and improvements in health status are primarily a result of social and environmental advances, medical care has had a substantial effect. Medical care can be demonstrated to be effective in preventing much of the mortality and morbidity in childhood and therefore in modifying the impact of low income on illness.

The benefits of medical care have recently been documented in a review of the literature concerning sixteen different indicators of ill health in childhood: neonatal mortality, postneonatal mortality, low birthweight, births to teenagers, bacterial meningitis, diabetic acidosis, asthma, appendicitis, immunizations and communicable diseases, congenital hypothyroidism and phenylketonuria, gastroenteritis and dehydration, epilepsy, lead poisoning, iron-deficiency anemia, rheumatic fever, and child batterings.

Evidence of the benefits of medical care is of two types: 1) Temporal relationships between a change in frequency and/or severity of a condition and a change in the nature or amount of health care delivered; 2) A relationship between an increase in complications or sequelae of illness and delay in seeking care.

The evidence is imperfect. For most conditions for which medical care is sought, evidence of effectiveness has not been documented by specific studies. Moreover, when studies do document the efficacy of particular modes of therapy, few include their application under usual conditions of practice and the extent to which various groups in the population have access to efficacious care. Nevertheless, the study cited above was able to conclude that "If the results of this literature review can be generalized to other conditions, much although by no means all of medical care can be said to have a beneficial effect; conversely, poorer access to medical care can be considered a risk factor for greater illness."

How Medicaid Has Helped Poor Children

Although some disparities in health status persist, gaps in the access to and utilization of health care have begun to close. The utilization of health care services by poor children now approximates that of the non-poor, but did not begin to do so until after the enactment of the Medicaid program. Aday et al report that, overall, 97 percent of the children in the United States ages 1-5 saw a physician in 1976; the range was from 97 percent of children in families with high incomes to 78 percent of those in low-income families. They noted similar ratios for children ages 6-17 in households of different income status. In 1963, before the enactment of Medicaid, however, the differences in utilization were much greater: only 52 percent of the younger children and 41 percent of the older group in low-income families saw a physician in the previous year, compared with 87 and 70 percent, respectively, in the high-income group. Other national studies have also confirmed the increased use of health services by poor children since enactment of Medicaid.

Medicaid has greatly improved access to health services for low-income children but has not yet eliminated all the disparities. The poorer the family, the more likely the children are to have no regular source of care and to have a place rather than a particular physician as their regular source of care.

The type of health insurance has a large impact on whether or not the child has a regular source of care, even when the family has a low income. For example, almost twice the proportion of poor children (income under 150 percent of poverty) who are uninsured lack a regular source of care as

compared with those on Medicaid and those with private or military insurance. Even with insurance, however, poor children with Medicaid and those who are uninsured are more likely to have a place without a particular physician as their regular source of care (37.5 and 38.9 percent respectively) than poor children with private or military insurance (29.9 percent). Individuals in each income group who are receiving Medicaid are less likely than those who are uninsured to be without a source of regular care but are at least equally likely of having a place rather than a particular doctor as their regular source of care.

Being poor and being on Medicaid are also associated with high proportions of children using hospital outpatient departments as their regular source of care. Dutton, in a study in Washington, D.C., demonstrated that certain types of organizations, particularly those that provided poor continuity of care and that provided care primarily to poor people achieved less satisfactory outcomes (such as fewer preventive services) than organizations providing greater continuity and serving heterogeneous populations. Low-income children are even less likely to have contact with a physician than other children if their greater illness is taken into account. Controlled for morbidity, poor children have many fewer visits than non-poor children.

Programs such as Medicaid not only have helped poor children get medical care, they have even had a demonstrable effect on the health of those children. The ameliorating effect of medical care on the poorer health status of disadvantaged children is demonstrated by the following:

1. Hospitalization rates among poor children increased after access to medical care was facilitated in the mid-1960s. Concomittantly, lengths of stay declined so that the disparities between the poor and the non-poor were much less than in the early 1960s.

2. There is now better diagnosis of specific major chronic illnesses among poor children than was the case previously. Prior to the mid-1960s, a much lower proportion of poor children were diagnosed as having diabetes than was the case for non-poor children. By the mid-1970s, almost equal proportions had diagnosed diabetes.

3. Subsequent to programs such as Medicaid, the disparity in postneonatal mortality rates between the poor and the non-poor narrowed.

4. In areas where access to better perinatal care was facilitated the gap in neonatal mortality rate between the poor and the non-poor narrowed.

In summary, better access to appropriate medical care can improve the health status of poor children. Poorer access to care is responsible, at least in part, for the greater severity of illness among poor as compared with non-poor children. Lack of access to timely and adequate medical care is clearly a risk factor for more severe illness in childhood.

It is important to note not only that Medicaid has helped, but also that Medicaid is overwhelmingly the most important means of providing health care to poor children. The Federal government does not spend many Medicaid dollars on health care for low-income children, but what it does

spend is critical. Expenditures for children comprise both a small proportion and a low absolute amount of Federal expenditures for health care. In 1978, public expenditures for child health care were $5.606 billion or 9.8 percent of the total public expenditures of $55.042 billion. Per capita public expenditures for children were $81.09, compared with $1,279.55 in public funds expended for those 65 and over, and $218.13 for those aged 19 to 64.

Medicaid accounts for the largest proportion of public funds that are spent for children. In 1978, Medicaid accounted for 55 percent of public funds spent for children's health, although that program accounted for only 28 percent of public expenditures for health care for all age groups and only 21 percent for those aged 65 and over. Although the aged have other sources of public spending, particularly Medicare, children receiving health care under public programs rely largely on Medicaid.

Studies by the Census Bureau document the importance of Medicaid for low-income children. In 1981, of those children below the poverty level who had some form of health insurance, two-thirds had only Medicaid. Private insurance alone covered only 18 percent of children below poverty. Since one-third of children in poverty already have no insurance, nearly four out of five such children would be completely uninsured without the Medicaid program.

Medicaid Coverage Is Heading In The Wrong Direction

As noted above, when all public and private insurance is counted, only two-thirds of children in poverty have any health care coverage. Medicaid

itself covers less than half these children. With the number of poor children increasing, one would expect to see a significant increase in the number of Medicaid recipients who are children. Unfortunately this has not happened. In fact, the number of child Medicaid recipients rose by only 3 percent between 1980 and 1982 -- far below the increase in numbers of poor children during that same time period. Moreover, the Children's Defense Fund (1983) recently surveyed each state and estimated that some 700,000 children and women have been dropped from the Medicaid rolls. This trend toward eligibility limits appears to have grown even worse in the last two years, due primarily to state changes or lack of improvements in eligibility under AFDC programs and medically needy programs.

For most children, Medicaid eligibility is the result of that child's qualifying for Aid to Families with Dependent Children (AFDC). States are free to set their financial standards for AFDC and Medicaid eligibility and, with few exceptions, choose incomes that are well below the poverty level. These income standards have constantly failed to keep pace with inflation. Consequently, AFDC recipients are poorer than ever before, and fewer poor children are eligible for AFDC and Medicaid. Moreover, since 1981 states have made a number of changes in both eligibility and benefits that have reduced coverage for low-income children.

In addition to financial standards that are more stringent than the poverty level, the major reason why so many poor children are not covered is the restriction of eligibility only to children in certain categories. AFDC is the largest and is included in all Medicaid programs, and most

disabled children receiving Supplemental Security Income (SSI) payments are also eligible for Medicaid.

Beyond the AFDC and SSI regulations, states have the option of covering additional groups of categorically needy children. Many states, however, have not taken advantage of these options. For example, in 1990 24 states did not cover poor children in two-parent unemployed families. Over ten years ago, Abraham Ribicoff wrote about this unfortunate regulation:

> The grim reality is that our welfare system, as now structured, encourages the disintegration of the family unit, and virtually forces fathers and mothes out of their homes. (Ribicoff, 1972, p.50)

Sixteen states denied coverage for prenatal care of pregnant women carrying their first child because these women were not yet parents and, consequently, not yet eligible for AFDC. This extremely unfortunate policy in high personal and societal costs increases the number of premature and low birth weight infants and in return means more public funds are spent on intensive care of such newborns.

Seventeen states excluded AFDC or SSI children ages 18-21 who are regularly attending school. Twenty states restricted financially eligible children under 21 who were not living with or had no parent from receiving Medicaid. An exception to the discrepancies in coverage listed above is the finding that all states have taken the option to cover children in orphanages, foster homes, and facilities for the mentally ill or mentally

retarded -- a group that would likely be a state responsibility anyway and, therefore, a Federal match for their payment reduces the states' share.

Another group of children that states can opt to cover are the medically needy. These are dependent children who live in families that meet all the criteria for categorically needed assistance, except for income and who have high medical bills. This could be a child with sickle cell anemia (requiring regular and costly care) who lives with a parent who may make only $10 more a month than is allowed to obtain Medicaid eligibility. Under the medically needy program, this parent would be able to subtract the cost of medical care from their monthly income and thereby become eligible for Medicaid. In 1981, there were an estimated 9 million medically needy (AFDC) children and 1.4 million other Title XIX recipients (the majority of whom are children), totally over 10 million children or 57 percent of all medically needy recipients. But, the following 20 states do not cover medically needy children as of 1983: Alabama, Alaska, Colorado, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Mississippi, Missouri, Nevada, New Jersey, New Mexico, Ohio, Oregon, South Carolina, South Dakota, Texas and Wyoming.

A final group of potentially eligible children live in families that do not meet any of the categorical requirements or they live in families with incomes above the Federally established maximum for the medically needy. Alien children, for example, would be covered in the former group. Unfortunately, there are no accurate estimates of the numbers of children in these groups.

The children in excluded categories and the increasing number of poor children ineligible for Medicaid are not the only reasons why the program should be expanded rather than constricted. Changes in Medicaid directly affect other Federal and state programs and private expenditures as well. The Crippled Childrens Services (CCS) have very limited funds that they have been able to target on ambulatory and other specialized services because many of the CCS children have also been eligible for Medicaid. Reductions in Medicaid mean that states may well see an increasing share of their CCS budgets going for in-hospital care -- a very costly shift that could rapidly exhaust CCS budgets. In the private sector, Medicaid cutbacks in eligibility, benefits and payment levels also increase the bad debt load on hospitals and physicians. This leads to cost-shifting to private patients, which in effect is a hidden tax on employers and individuals who require hospitalization. The unstable situations that result have produced crises for industry, insurance companies and providers.

The deleterious effects of Medicaid restrictions on chidren have by no means all been measured as yet, and many may not appear for years. In his testimony today, Dr. C. Arden Miller has documented some indications of these ill effects. Preliminary results from an on-going study of pediatricians who were mainly working in teaching clinics show the impact of Medicaid and other program cuts. Two-thirds of the nearly 400 respondents either reported a reduction in services, in the most recent year or volunteered at least one effect of reductions. Almost half reported reductions having to do with Medicaid. About one-third reported

increases used by those who used to seek care elsewhere and larger numbers of families with no insurance and unable to afford treatment.

Conclusion

Medicaid is the most important program the Federal government has ever established for health care needs of poor children. It has opened the door to care for many children. Many other poor children -- more than half -- was never covered, however, because their numbers are increasing. Reforms may be necessary, controls on spending increases may be necessary, but not ones that deny medical care to children in poverty. I strongly support the position of the American Academy of Pediatriains that all children have a right to health care and that children should be covered by a comprehensive public plan when families are unable to provide for adequate health financing. This should be the goal of our country, and we should move toward, and not away from, meeting that goal.

Senator BENTSEN. Dr. Budetti, Dr. Miller's analysis concluded that the Federal Government did exactly the wrong thing in 1981 when it cut child health programs. I was looking at the chart up there where it shows that our infant mortality rate has continued to go down despite the cuts. That is misleading.

The problem is that mortality statistics traditionally are a lagging indicator in displaying what happens with spending cuts. Do either of you have any more recent data that give any better indication of the impact on maternal and child health of the 1981 cuts?

Dr. BUDETTI. I think we would both like to answer. Go ahead, Dr. Eaton.

Dr. EATON. I am very much aware that the State of Michigan has done a study which has illustrated the disastrous effects of the cutbacks in maternal and child health programs which I think is very significant in that the State of Michigan has probably had one of the best maternal and child health care programs nationally that exists.

There are specific figures that I think will illustrate even at this point, relatively early in the game, that infant mortality is rising. I am also very much aware that in my own hometown of Youngstown, Ohio—which, as you are well aware, has high unemployment—there has been an increase in the infant mortality rate over the last year or two.

Senator BENTSEN. Dr. Budetti, the Center for Disease Control in Atlanta is very proud of its immunization record and what they have been able to achieve in sharply decreasing the instance of some of the dread diseases like polio. These programs have been very cost effective.

For example, we had a special case some years ago down in Texas, and elsewhere, with rubella and 3-day measles. As a direct result of that incident years ago, Congress just recently had to increase the Gallaudet College funding to deal with the sharp increase in the number of young students with rubella-caused deafness as they entered their college years. We were pennywise and pound foolish years ago. Now, today, while it is at a record low nationally, Texas has quite a problem with rubella cases originating in Mexico. Do you know if these kinds of immunization programs are taking place in nations like Mexico?

Dr. BUDETTI. I am not aware of what Mexico's immunization programs consist of, Senator.

Senator BENTSEN. I think that is the kind of thing Dr. Miller would have been a very good person to speak on. But, I do think that is an excellent example of the widsom, from even a strictly cost basis, for these programs. We used to have a great deal of rubella as well as many other infectious diseases. And, if we cut back on immunization programs, those diseases are certain to increase.

I think Dr. Eaton's citation of preliminary evidence about infant mortality rates makes the point that if we wait until we have statistically significant data, a lot of babies will be born in poor health or even die before we become really convinced that things are going downhill. Instead, we should look at the past and look at the situation in other countries with different programs to see what to expect—to determine what will happen if we cut back on these programs.

Dr. Budetti, do you know if some of those countries have vaccination programs that we do not have?

Dr. BUDETTI. No. The only programs that I am aware of, worldwide, are vaccination programs against tuberculosis that we have not adopted for a variety of both medical and public health reasons. But I am not aware of other similar kinds——

Of course, areas with major infectious diseases like cholera have programs, too; but, no, I am not aware. That is just not my field. I am sorry.

Senator BENTSEN. Dr. Eaton, you have an association with the border health program.

Dr. EATON. Right.

Senator BENTSEN. I have an interest in that having been born and reared in that area, and having some idea of the severe problems they have.

Can you tell me briefly how the health care situation along the southern border differs from the rest of the nation?

Dr. EATON. I guess the best way to capsulize an answer, since the research that has taken place in this United States-Mexican border project probably has taken place over a 3-year period—and, incidentally involved LBJ School of Public Affairs in Austin as well as the Academy of Pediatrics' Committee on Community Health Services—is that there are very significant problems in maternal and child health along the border and on both sides of the border.

Basically, the intent of this research was to illustrate what the magnitude of those problems were. For example, looking at indexes such as infant mortality death due to infectious diseases and a variety of other factors, that research data is at this point being analyzed and finalized, and I think will be of great interest to you personally because I think it is the first attempt to, in a systematic way, look at the border areas between Mexico and the United States in a very formal research process.

Senator BENTSEN. Looking at these charts, Dr. Budetti, when you talk about the MCH block grant program and childhood immunization programs, you are talking about preventive care. Medicaid and community health centers on the other hand are more reactive in nature.

Japan and most European nations, as we see from the chart on infant mortality rates abroad, are doing a better job of providing help to newborns than we are. What accounts for their better performance? What kind of a blend do they have of preventive and reactive health programs? How do the expenditures compare with ours?

Dr. BUDETTI. A big difference in most of those countries is birthweight. We have a higher infant mortality rate than many of those countries simply because we have more very small babies born in this country.

One of the main reasons that is the case is that, in many of those countries, women all get adequate prenatal care; they have sound nutrition and nutrition counseling programs. Healthier mothers are having bigger, healthier babies, and so once the babies are born, they are much more likely to live.

If you look at how well we are doing once the babies in the country are born, the tiniest babies are doing much better than in those countries. The problem is that we have more tiny babies because we have

not been doing the kinds of things that will prevent or reduce the number of premature babies.

Figures in the six or seven range of infant mortality indicate causes that it is very difficult to eliminate. But at our range, 12.5, that number could probably be cut by half or a third by reducing the frequency of deaths from prematurity and low birthweight. It is principally at the mother's end of things where our failing is.

Senator BENTSEN. The administration is doing harm in cutting child nutrition programs and the MCH block grant. But in the next session, I expect to offer an amendment on the Senate floor to increase the MCH block grant appropriation for fiscal year 1984—to get the MCH program a higher level of funding, instead of a cut in funds.

What I would like from the two of you are good arguments to use in front of the Senate for that purpose. I will not ask you to do it here today, but if you can send me some information, I would be very appreciative of that.

Dr. BUDETTI. I believe we both believe there are some very good arguments and will be happy to supply them to you.

Dr. EATON. With great enthusiasm.

Senator BENTSEN. The usual problem I have with the Senate is trying to be in two places at one time. In fact, I am supposed to be at another hearing right now. So let me adjourn this hearing and continue my examination of the MCH program cuts on December 17, 1984.

I appreciate both of you presenting testimony today. It is a good deal to digest, but I will put it to good use next year. Thank you, again, for your thoughtful testimony.

Dr. EATON. Thank you.

Dr. BUDETTI. Thank you.

[Whereupon, at 11 a.m., the subcommittee adjourned, subject to the call of the Chair.]

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